

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035741

Facility Name: LAHARPE-DAVIER HEALTH CARE CENTER

Address: B STREET & ARCHER AVENUE LAHARPE 61450

County: HANCOCK

Telephone Number: (217) 659-3222 Fax # (217) 659-3017

IDPA ID Number: 37-0619841002

Date of Initial License for Current Owners: 07/21/22

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: MS. JENNIFER WIRT Telephone Number: (217) 659-3222

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/99 to 09/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) MS. JENNIFER J. WIRT

(Title) ADMINISTRATOR

Paid Preparer

(Signed) SEE COMPILATION REPORT (Date)

(Print Name and Title) TONY CAWIEZELL, SR. MANAGER

(Firm Name & Address) McGLADREY & PULLEN, LLP 220 N. MAIN, DAVENPORT IA 52801

(Telephone) (319) 326-5111 Fax # (319) 324-6939

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

LAHARPE-DAVIER HEALTH CARE CENTER

#

0035741

Report Period Beginning:

10/01/99

Ending:

09/30/00

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,934	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	10,463	6,092		16,555	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,463	6,092		16,555	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)

92.31%

D. How many bed-hold days during this year were paid by Public Aid?
25 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census?
YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

I. On what date did you start providing long term care at this location?
Date started 10/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 9/30/00 Fiscal Year: 9/30/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number

LAHARPE-DAVIER HEALTH CARE CEN

#

0035741

Report Period Beginning:

10/01/99

Ending:

09/30/00

Page 3

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	97,321	9,842	5,340	112,503	(16,836)	95,667	(3,132)	92,535			1
2	Food Purchase		88,469		88,469		88,469		88,469			2
3	Housekeeping	47,074	8,812	934	56,820		56,820		56,820			3
4	Laundry			10,595	10,595		10,595		10,595			4
5	Heat and Other Utilities			48,713	48,713		48,713	(94)	48,619			5
6	Maintenance	37,328	29,850	6,071	73,249	(1,597)	71,652		71,652			6
7	Other (specify):*											7
8	TOTAL General Services	181,723	136,973	71,653	390,349	(18,433)	371,916	(3,226)	368,690			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	558,309	3,017	28,335	589,661	(3,017)	586,644	(250)	586,394			10
10a	Therapy											10a
11	Activities	24,707	995	2,334	28,036	(328)	27,708		27,708			11
12	Social Services	18,192	437	1,757	20,386	(553)	19,833		19,833			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* DAY CARE	49,012	2,132	2,257	53,401	27,796	81,197	(81,197)				15
16	TOTAL Health Care and Programs	650,220	6,581	34,683	691,484	23,898	715,382	(81,447)	633,935			16
	C. General Administration											
17	Administrative	46,952			46,952		46,952		46,952			17
18	Directors Fees											18
19	Professional Services			21,791	21,791		21,791		21,791			19
20	Dues, Fees, Subscriptions & Promotions			5,336	5,336	2,326	7,662	(5,336)	2,326			20
21	Clerical & General Office Expenses	38,659	3,775	26,249	68,683	(9,911)	58,772	(8,206)	50,566			21
22	Employee Benefits & Payroll Taxes			87,931	87,931	18,030	105,961		105,961			22
23	Inservice Training & Education					7,503	7,503		7,503			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			27,068	27,068	(22,554)	4,514		4,514			26
27	Other (specify):* BAD DEBTS			13,066	13,066		13,066	(13,057)	9			27
28	TOTAL General Administration	85,611	3,775	181,441	270,827	(4,606)	266,221	(26,599)	239,622			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	917,554	147,329	287,777	1,352,660	859	1,353,519	(111,272)	1,242,247			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SEE ACCOUNTANTS' COMPILATION REPORT

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			54,588	54,588		54,588	(4,735)	49,853			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,731	36,731		36,731	(2,949)	33,782			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			91,319	91,319		91,319	(7,684)	83,635			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,900	26,900		26,900		26,900			42
43	Other (specify):* CLINIC	35,106	14,478	107,482	157,066	(859)	156,207	(7,150)	149,057			43
44	TOTAL Special Cost Centers	35,106	14,478	134,382	183,966	(859)	183,107	(7,150)	175,957			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	952,660	161,807	513,478	1,627,945		1,627,945	(126,106)	1,501,839			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$ (81,197)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,132)	1		4
5	Telephone, TV & Radio in Resident Rooms	(94)	5		5
6	Rented Facility Space	(7,150)	43		6
7	Sale of Supplies to Non-Patients	(250)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,949)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(4,735)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(5,336)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,057)	27		24
25	Fund Raising, Advertising and Promotional	(7,499)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(707)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (126,106)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (126,106)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch, V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
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72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	0	90

Summary A

09/30/00

[illegible]

Summary B

09/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAHARPE-DAVIER HEALTH CARE CENTER # 0035741 Report Period Beginning: 10/01/99 Ending: 09/30/00

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	GECC		X	CONSTRUCTION COSTS	\$5,662.00	04/07/76	\$ 1,146,000	\$ 717,791	04/07/16	5.0000	\$ 36,731	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$5,662.00		\$ 1,146,000	\$ 717,791			\$ 36,731	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,146,000	\$ 717,791			\$ 36,731	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

16	AMOUNT TO USE FOR RATE CALCULATION \$	16
----	---------------------------------------	----

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,944

B. General Construction Type: Exterior BRICK Frame BRICK Number of Stories 3

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	HEALTH CARE CENTER		1922-1976	\$ 41,633	1
2	LAUNDRY EXPANSION		1977	5,911	2
3	TOTALS			\$ 47,544	3

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 281,127	\$ 12,682	\$ 12,682	\$	VARIOUS	\$ 212,569	37
38	Current Year Purchases	10,812	1,306	1,306		VARIOUS	1,306	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 291,939	\$ 13,988	\$ 13,988	\$		\$ 213,875	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 2,163,306	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 49,853	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 49,853	49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,589,369	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	RENTAL PROPERTY	\$ 45,489	\$ 1,691	\$ 7,640	52
53	CLINIC	26,363	3,044	12,541	53
54					54
55					55
56					56
57	TOTALS	\$ 71,852	\$ 4,735	\$ 20,181	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$
- Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	\$
13.	/2002	\$
14.	/2003	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF AIDES TRAINED

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

In the box below record the amount of income your facility received training aides from other facilities.	
\$	

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 91,280	\$	1
2	Cash-Patient Deposits	174,094		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	116,506		3
4	Supply Inventory (priced at)	2,500		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,542		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 385,922	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	168,614		12
13	Land	99,485		13
14	Buildings, at Historical Cost	1,864,436		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	318,302		16
17	Accumulated Depreciation (book methods)	(1,609,549)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	51,112		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 892,400	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,278,322	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 38,087	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	32,801		29
30	Accrued Salaries Payable	56,818		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ESTIMATED SETTLEMENT	(335)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 127,371	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	684,990		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 684,990	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 812,361	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 465,961	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,278,322	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 565,716	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 565,716	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(99,755)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (99,755)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 465,961	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,386,899	1
2	Discounts and Allowances for all Levels	(124,801)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,262,098	3
	B. Ancillary Revenue		
4	Day Care	43,627	4
5	Other Care for Outpatients	173,385	5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 217,012	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,588	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	19,745	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 22,333	23
	D. Non-Operating Revenue		
24	Contributions	3,140	24
25	Interest and Other Investment Income***	23,965	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,105	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	UNREALIZED GAIN ON INVESTMENTS	(358)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (358)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,528,190	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services		31
32	Health Care		32
33	General Administration	1,627,945	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	<u>Rounding</u>		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,627,945	40
41	Income before Income Taxes (line 30 minus line 40)**	(99,755)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (99,755)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,720	1,720	\$ 18,020	\$ 10.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,520	13,841	217,355	15.70	3
4	Licensed Practical Nurses	5,398	5,785	64,072	11.08	4
5	Nurse Aides & Orderlies	32,566	36,019	258,862	7.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,808	3,090	24,707	8.00	9
10	Activity Assistants					10
11	Social Service Workers	1,959	2,197	18,192	8.28	11
12	Dietician	12,422	13,722	97,321	7.09	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,723	4,211	37,328	8.86	17
18	Housekeepers	6,402	6,997	47,074	6.73	18
19	Laundry					19
20	Administrator	2,080	2,080	46,952	22.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,896	4,313	38,659	8.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) CLINIC	9,957	10,937	84,118	7.69	33
34	TOTAL (lines 1 - 33)	95,451	104,912	\$ 952,660 *	\$ 9.08	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		LAHARPE-DAVIER HEALTH CARE CENTER		STATE OF ILLINOIS	#	0035741	Report Period Beginning:	10/01/99	Ending:	09/30/00	Page 23
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>NO</u>							
(2)	Are there any dues to nursing home associations included on the cost report?			<u>YES</u>							
	If YES, give association name and amount.			<u>ILLINOIS HOSPITAL ASSOCIATION \$2,326 A/C# 96500</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization?			<u>NO</u>							
	If YES, have these costs been properly adjusted out of the cost report?			<u>N/A</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?			<u>NO</u>							
	If YES, what is the capacity?			<u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases?			<u>YES</u>							
	What was the average life used for new equipment added during this period?			<u>10</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>7,966</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			<u>YES</u>							
	If NO, attach a complete explanation.										
(8)	Are you presently operating under a sale and leaseback arrangement?			<u>NO</u>							
	If YES, give effective date of lease.			<u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES <u>NO</u> <u>X</u>							
	If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.										
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.			\$ <u>26,900</u>							
	This amount is to be recorded on line 42 of Schedule V.										
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?			<u>NO</u>							
	If YES, attach an explanation of the allocation.										
SEE ACCOUNTANTS' COMPILATION REPORT											
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			<u>YES</u>							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?			<u>YES</u>							
	For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.										
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.			\$ <u>0</u>							
	Has any meal income been offset against related costs?			<u>YES</u>							
	Indicate the amount.			\$ <u>2,588</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel?			<u>NO</u>							
	If YES, attach a complete explanation.										
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			<u>NO</u>							
	If YES, please indicate the amount of income earned from such a program during this reporting period.			\$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>NONE</u>							
	d. Have vehicle usage logs been maintained?			<u>N/A</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training?			<u>NO</u>							
	Indicate the amount of income earned from providing such transportation during this reporting period.			\$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm?			<u>YES</u>							
	Firm Name:			<u>McGLADREY & PULLEN, LLP</u>							
	The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?			<u>YES</u>							
	If no, please explain.										
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>YES</u>							
(19)	If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?			<u>N/A</u>							
	Attach invoices and a summary of services for all architect and appraisal fees										